

STATEMENT OF CONSIDERATION RELATING TO  
907 KAR 1:044

Department for Medicaid Services  
Amended After Comments

(1) A public hearing regarding 907 KAR 1:044 was not requested and; therefore, not held.

(2) The following individuals submitted written comments regarding 907 KAR 1:044:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Owen T. Nichols, Psy. D, MBA, ABPP, ABMP, Chair	Kentucky Board of Examiners of Psychology
Sheila A. Schuster, Ph.D.,KPA Legislative Liason	Kentucky Psychological Association
Lisa Willner, Ph.D., KPA Executive Director	Kentucky Psychological Association
Steve Shannon, Executive Director	Kentucky Association Regional Programs, Inc. (KARP)
Bart Baldwin, Director	Kentucky Health Resources Alliance
Kathy Adams, Director of Public Policy	The Children's Alliance

(3) The following individual from the promulgating agency responded to comments received regarding 907 KAR 1:044:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Stuart Owen, Regulation Coordinator	Department for Medicaid Services
Kristina Hayden, Internal Policy Analyst	Department for Medicaid Services
Leslie Hoffmann, Director	Department for Medicaid Services, Division of Community Alternatives

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Supervision

(a) Comment: Dr. Lisa Willner, Executive Director of the Kentucky Psychological Association, and Dr. Sheila A. Schuster, Legislative Liaison of the Kentucky Psychological Association, stated the following:

"Page 3.2 (3) Licensed Psychologist

We note that the CMHC Manual indicates that the Licensed Psychologist may provide

supervision of certified psychologists with autonomous functioning. While administrative supervision may be provided, the latter are licensed as independent practitioners under KRS 319 and are not required to have clinical supervision. This same status is enjoyed by Licensed Psychological Practitioners. On the other hand, Certified Psychologists and Licensed Psychological Associates are required under KRS 319 to have clinical supervision by a Licensed Psychologist in order to practice. We request that the language be changed: The licensed psychologist may provide clinical supervision of certified psychologists and licensed psychological associates.

In that same subsection, the second sentence begins 'This staff recipient may be utilized...' We see no definition of a 'staff recipient'. What is a 'staff recipient' and how does it describe a Licensed Psychologist? We request that the sentence be changed to read: 'The licensed psychologist may be utilized....'"

(b) Response: DMS is revising the manual to delete the supervisory language altogether and simply defining "licensed psychologist as follows:

**"(3) The following practitioners or staff shall be authorized to provide services or perform duties in a CMHC as follows:**

**(a) A licensed psychologist defined as an individual who:**

**1. Currently possesses a licensed psychologist license in accordance with KRS 319.010(6); and**

**2. Meets the licensed psychologist requirements established in 201 KAR Chapter 26[a psychologist licensed in accordance with the requirements set forth in KRS 319. This staff recipient may be utilized to lead diagnostic conferences upon assignment by the center director. The licensed psychologist may provide supervision of certified psychologist(s) with autonomous functioning]."**

DMS is correcting the typo regarding "staff recipient" by changing the term to "staff."

(c) Comment: Dr. Lisa Willner, Executive Director of the Kentucky Psychological Association, and Dr. Sheila A. Schuster, Legislative Liaison of the Kentucky Psychological Association, stated the following:

**"Page 3.3 (6). Program Director: The Certified Psychologist with Autonomous Functioning and the Licensed Psychological Practitioner are the equivalent in education (Master's degree) and have more required supervised experience before becoming independently licensed than the licensed professionals clinical counselor, licensed marriage and family therapist and licensed clinical social worker. Therefore, we request that 'certified psychologist with autonomous functioning' and 'licensed psychological practitioner' be added to the list of those professionals eligible to be CMHC Program Directors."**

(d) Response: As the Office of Inspector General establishes CMHC licensure requirements in administrative regulation (902 KAR 20:091) including program director

requirements, DMS is replacing the current language by referring to the OIC licensure regulation as follows:

**“(d) A[(6)] program director who shall meet the program director requirements established in 902 KAR 20:091[;—The program director shall be a qualified mental health professional who shall be a psychiatrist, psychologist, psychiatric nurse, licensed professional clinical counselor, licensed marriage and family therapist, or a licensed clinical social worker. The program director may also be the executive director].”**

(e) Comment: Dr. Lisa Willner, Executive Director of the Kentucky Psychological Association, and Dr. Sheila A. Schuster, Legislative Liaison of the Kentucky Psychological Association, stated the following:

“Beginning on page 3.3 and ending on page 3.10, the CMHC manual provides for ‘supervision’ of various categories of providers by a wide range of mental health professionals. We are greatly concerned that this section does not appear to take into account the statutory requirements set forth by the individual licensure boards for the appropriate clinical supervision of those practitioners who have not gained independent practice status. We believe it is critical to make a distinction between ‘administrative’ or perhaps ‘billing’ supervision and clinical supervision! Therefore, we request that ‘billing’ be inserted before the word “supervision” for each category of Additional Staff referenced in D.

We also urge DMS to insert this language at the beginning of subsection D: ‘The arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not violate nor substitute for the clinical supervision rules or policies of the respective professional licensure board governing the behavioral health practitioner under supervision.’”

(f) Response: DMS is amending the manual by rephrasing references to supervision or supervising professional to “billing supervision” or “billing supervisor”, by delineating the authorized billing supervisors (as follows) and by inserting the recommended language regarding the respective licensure boards also as follows:

### **C. Billing Supervision.**

#### **(1) A billing supervisor shall be an individual who is:**

##### **(a)1. A physician;**

##### **2. A psychiatrist;**

##### **3. An advanced practice registered nurse;**

##### **4. A licensed psychologist;**

##### **5. A licensed clinical social worker;**

##### **6. A licensed professional clinical counselor;**

##### **7. A licensed psychological practitioner;**

##### **8. A certified psychologist with autonomous functioning;**

**9. A licensed marriage and family therapist;**  
**10. A licensed professional art therapist; or**  
**11. A licensed behavior analyst; and**  
**(b) Employed by or under contract with the same community mental health center as the behavioral health practitioner under supervision who renders services under the supervision of the billing supervisor.**

**(2) The arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not violate nor substitute for the clinical supervision rules or policies of the respective professional licensure board governing the behavioral health practitioner under supervision.”**

(g) Comment: Dr. Lisa Willner, Executive Director of the Kentucky Psychological Association, and Dr. Sheila A. Schuster, Legislative Liaison of the Kentucky Psychological Association, stated the following:

“We note that the CMHC Manual lists in Subsection D every other mental health licensure category and title, with the exception of “Certified Psychologist with Autonomous Functioning” as being authorized to provide (“billing”) supervision. We acknowledge that the Department of Medicaid Services has chosen by regulation to include this title under the title “Licensed Psychological Practitioner”, but this is not consistent with state law (KRS 319.056), nor with the title given by the KY Board of Examiners of Psychology and lawfully required to be used by these practitioners. They are not “Licensed Psychological Practitioners”!

We note that “Certified Psychologist with Autonomous Functioning” has correctly been included in these lists:

Page 3.4 (2) Mental Health Associate  
Page 3.7 (15) Community Support Associate  
Page 3.7-3.8 (16) Peer Support Specialist  
Page 3.9 (17) Certified Alcohol and Drug Counselor

We urgently request that “Certified Psychologist with Autonomous Functioning” be added to the following lists for purposes of consistency and legal usage:

Page 3.3 (1) Professional Equivalent  
Page 3.5 (6) Licensed Professional Counselor Associate  
Page 3.5-3.6 (11) Certified Social Worker  
Page 3.6 (12) Licensed Psychological Associate. NOTE: The Licensed Psychological Associate is the equivalent of the Certified Psychologist, not the Certified Psychologist with Autonomous Functioning.  
Page 3.6 (13) Marriage and Family Therapy Associate  
Page 3.9-3.10 (19) Licensed Professional Art Therapy Associate  
Page 3.10 (21) Licensed Assistant Behavior Analyst.”

(h) Response: DMS is revising the manual by inserting “certified psychologists with autonomous functioning” as authorized practitioners (or supervisors) in each place in which a licensed psychological practitioner is listed as an authorized practitioner or

supervisor.

DMS is also inserting the following definition of “certified psychologist with autonomous functioning” in the staffing section of the manual:

**“(n) A certified psychologist with autonomous functioning defined as an individual who is a certified psychologist with autonomous functioning pursuant to KRS 319.056.”**

(i) Comment: Dr. Lisa Willner, Executive Director of the Kentucky Psychological Association, and Dr. Sheila A. Schuster, Legislative Liaison of the Kentucky Psychological Association, stated the following:

“Page 4.5 2nd paragraph of 8.A: Same comment and rationale as provided on Page 3.3 (6) for Program Director: We request that the following practitioners be added to the list of those authorized to provide supervision of therapeutic rehabilitation programs:

**‘licensed psychological practitioner, certified psychologist with autonomous functioning, licensed psychological associate, certified psychologist’.**”

(j) Response: DMS is removing the supervision language from that particular section of the manual as the manual elsewhere delineates who can provide and supervise therapeutic rehabilitation services. Elsewhere in the manual DMS is revising the language to include licensed psychological practitioners and certified psychologists with autonomous functioning (but not licensed psychological associates or certified psychologists” as those authorized to supervise therapeutic rehabilitation services and is including all four (4) professionals – licensed psychological practitioners, certified psychologists with autonomous functioning, licensed psychological associates, and certified psychologists as those authorized to provide therapeutic rehabilitation services.

(k) Comment: Dr. Owen T. Nichols, Chair of the Kentucky Board of Examiners of Psychology, stated the following:

“The proposed language implies that licensed non-psychological professionals may provide clinical supervision to a licensed psychological associate. Second, your definition of a licensed psychological associate includes a definition of a certificated psychologist with autonomous functioning, which would require supervision under the proposed regulatory change.”

(l) Response: DMS is revising the Community Mental Health Center Behavioral Health Services Manual to restrict licensed psychological associates to working under the supervision of a board-approved licensed psychologist.

DMS is also revising the definition of licensed psychological associate as follows:

**“(p)1. A[(12)] Licensed psychological associate defined as[~~:- A licensed psychological associate means~~] an individual who:**

**a.1.]** Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and

**b.2.]** Meets the licensed psychological associate requirements established in **Title 201,** Chapter 26 of the Kentucky Administrative Regulations~~;~~**or**  
**(b) Is a certified psychologist with autonomous functioning].**

**2.** A licensed psychological associate may provide services as stated in the covered services section of this manual (Section IV) but only under the supervision of **a board-**  
**approved[any of the following:**

**1. Physician**

**2. Psychiatrist**

**3. Advanced Practice Registered Nurse**

**4.] licensed psychologist in accordance with:**

**a. KRS 319.064(5); and**

**b. 201 KAR 26:171**

**[5. Licensed Psychological Practitioner**

**6. Licensed Clinical Social Worker**

**7. Licensed Professional Clinical Counselor**

**8. Licensed Marriage and Family Therapist**

**9. Licensed Professional Art Therapist**

**10. Licensed Behavior Analyst]**~~[a licensed psychologist].~~

(m) Comment: Dr. Owen T. Nichols, Chair of the Kentucky Board of Examiners of Psychology, stated the following:

“The proposed regulation would allow a licensed psychological associate to be supervised by licensed individuals from other professions. A licensed psychological associate may only provide services under the supervision of a board-approved licensed psychologist. See KRS 319.064(5) and 201 KAR 26:171.”

(n) Response: DMS is revising the Community Mental Health Center Behavioral Health Services Manual to restrict licensed psychological associates to working under the supervision of a board-approved licensed psychologist.

(o) Comment: Dr. Owen T. Nichols, Chair of the Kentucky Board of Examiners of Psychology, stated the following:

“A certified psychologist with autonomous functioning is the equivalent of a licensed psychological practitioner. Neither credentialed professional must be supervised to engage in the practice of psychology. KRS 319.056(2) allows a certified psychologist with autonomous functioning to practice without supervision unless the board revokes his or her license. Additionally, neither certified psychologist with autonomous functioning nor a licensed psychological practitioner may supervise a certified psychologist, licensed psychological practitioner, or a licensed psychological associate. SEE KRS 319.056(2). However, under the proposed regulation, a licensed psychological practitioner would be allowed to supervise a certified psychologist,

licensed psychological practitioner, or a licensed psychological associate.”

(p) Response: DMS is inserting a definition of “certified psychologist with autonomous functioning” as follows:

**“(n) A certified psychologist with autonomous functioning defined as an individual who is a certified psychologist with autonomous functioning pursuant to KRS 319.056.”**

DMS is revising the requirements regarding a licensed psychological associate and a certified psychologist as follows:

**“(p)1. A[(12)] Licensed psychological associate ~~defined as~~[- A licensed psychological associate means]** an individual who:

**a.[(a)1.]** Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and

**b.[2.]** Meets the licensed psychological associate requirements established in **Title 201**, Chapter 26 of the Kentucky Administrative Regulations[; ~~or~~  
**(b) Is a certified psychologist with autonomous functioning**].

**2.** A licensed psychological associate may provide services as stated in the covered services section of this manual (Section IV) but only under the supervision of **a board-approved**[**any of the following**]:

**1. Physician**

**2. Psychiatrist**

**3. Advanced Practice Registered Nurse**

**4.] licensed psychologist in accordance with:**

**a. KRS 319.064(5); and**

**b. 201 KAR 26:171**

**[5. Licensed Psychological Practitioner**

**6. Licensed Clinical Social Worker**

**7. Licensed Professional Clinical Counselor**

**8. Licensed Marriage and Family Therapist**

**9. Licensed Professional Art Therapist**

**10. Licensed Behavior Analyst]**[a licensed psychologist].

**(q)1. A certified psychologist defined as an individual who is recognized as a certified psychologist in accordance with Title 201, Chapter 26 of the Kentucky Administrative Regulations.**

**2. A certified psychologist may provide services as stated in the covered services section of this manual (Section IV) but only under the supervision of a board-approved licensed psychologist in accordance with:**

**a. KRS 319.064(5); and**

**b. 201 KAR 26:171.”**

DMS is also inserting the following language, regarding supervision, into the manual:

**“(2) The arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not violate nor substitute for the clinical supervision rules or policies of the respective professional licensure board governing the behavioral health practitioner under supervision.”**

(q) Comment: Dr. Owen T. Nichols, Chair of the Kentucky Board of Examiners of Psychology, stated the following:

“Please consider adding a term such as “administrative” supervision to clarify that this regulation is not related to the clinical practice of psychology nor the clinical supervision of those practicing psychology in accordance with KRS Chapter 319.”

(r) Response: DMS is inserting the following language into the manual regarding supervision:

**“C. Billing Supervision.**

**(1) A billing supervisor shall be an individual who is:**

**(a)1. A physician;**

**2. A psychiatrist;**

**3. An advanced practice registered nurse;**

**4. A licensed psychologist;**

**5. A licensed clinical social worker;**

**6. A licensed professional clinical counselor;**

**7. A licensed psychological practitioner;**

**8. A certified psychologist with autonomous functioning;**

**9. A licensed marriage and family therapist;**

**10. A licensed professional art therapist; or**

**11. A licensed behavior analyst; and**

**(b) Employed by or under contract with the same community mental health center as the behavioral health practitioner under supervision who renders services under the supervision of the billing supervisor.**

**(2) The arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not violate nor substitute for the clinical supervision rules or policies of the respective professional licensure board governing the behavioral health practitioner under supervision.”**

(s) Comment: Bart Baldwin, Director of the Kentucky Health Resources Alliance, stated the following:

**“Page 3.4 Appendix I application process for professional equivalency.**



It is requested that staff who are certified, i.e. LPCA, CSW, LPA, MFTA, etc. be permitted to supervise persons designated as Professional Equivalent as they are one level above the Professional Equivalent.”

(t) Response: Professional equivalents are not below the level of associate-level practitioners but are equivalent; therefore, the associate-level practitioners are not authorized to supervise professional equivalents.

(2) Subject: Plan of Care

(a) Comment: Dr. Lisa Willner, Executive Director of the Kentucky Psychological Association, and Dr. Sheila A. Schuster, Legislative Liaison of the Kentucky Psychological Association, stated the following:

“The Manual states in this paragraph that the plan of care may be signed by a clinically licensed or certified professional provider of treatment, as stated in Section III, C (2-5) and D (1-7). C (5) describes the Medical Records Librarian, who would not be clinically licensed, nor should that individual be signing a plan of care! We request that the reference be: **‘Section III, C (2-4)’**. Further, the reference to D (1-7) includes Professional Equivalents and Mental Health Associates as well as LPPC Associates, but omits Psychiatric Resident Physicians, Licensed Clinical Social Workers and Licensed Psychological Practitioners, all of whom have higher education and clinical training. We request that the reference be: **‘Section III, D (3, 4, 5, 7, 8, 9 and 10)’**. Finally, the last sentence of that paragraph refers to ‘staff recipient’, a term which is not defined (noted in comment on Page 3.2 (3)) and makes no sense. We recommend that another term be chosen, such as **‘consultant’**.”

(b) Response: Rather than repeat the authorized supervisors (as they are stated elsewhere in the manual) DMS is revising the manual as follows:

“There shall be staffing conferences following screening to discuss cases, establish diagnosis or clinical impression, recommend additional evaluations and formulate a comprehensive [treatment] plan of care which shall include short term and long range goals as well as treatment modalities. Each client receiving direct treatment under the auspices of a community mental health center shall have an individual plan of care signed by a clinically licensed or certified professional **authorized to provide services in accordance with this manual – the Community Mental Health Center Behavioral Health Services Manual**~~[provider of the treatment, as stated in Section III, C(2-5) and D(1-7)]~~.”

(c) Comment: Steve Shannon, Executive Director of the Kentucky Association of Regional Programs stated the following:

“Language – The plan of care shall be reviewed every thirty (30) days thereafter and updated every sixty (60) days or earlier if clinically indicated.

Proposed Amended Language – The plan of care shall be reviewed every ~~thirty (30)~~ **ninety (90)** days thereafter and updated every ~~sixty (60)~~ **one hundred and eighty (180)** days or earlier if clinically indicated.

Rationale for proposed amendment – The CMHCs provide support and services to many individuals whose support needs do not change significantly over a thirty day period. In addition, the language indicating review and updated as clinically indicated directs the multidisciplinary team to address changes in the individual's plan of care as necessary. It does not appear to be necessary to review plans every thirty days for individuals who have not displayed significant new or different service and support needs; however we acknowledge that some services are more intensive which may justify a thirty day review. If all services require a thirty day review this will have the consequence of additional administrative expense for the CMHCs and will not necessarily result in better services, supports and outcomes for individuals served and supported.”

Bart Baldwin, Director of the Kentucky Health Resources Alliance, stated the following:

“**Page 3.14** The plan of care shall be reviewed every thirty (30) days thereafter and updated every sixty (60) days or earlier if clinically indicated. Realistically, the expectation that a plan of care be updated every 60 days will not be met. Clients on medication monitoring are only scheduled one time every three months and an update will be required before the client is even seen by a clinician. This requirement will have the outcome of a facility have charts out of compliance with the regulation.”

#### **SUGGESTED LANGUAGE:**

**The plan of care shall be reviewed every thirty (30) days thereafter and updated every ninety (90) days or earlier if clinically indicated.”**

(d) Response: The thirty (30) day requirement, in contrast to what the manual states, only applies to residential services for substance use disorders and intensive outpatient program services; thus, DMS is correcting the manual by revising the language as follows:

“A plan of care shall:

(a) Describe the services to be provided to the recipient, including the frequency of services;

(b) Contain measurable goals for the recipient to achieve, including the expected date of achievement for each goal;

(c) Describe the recipient's functional abilities and limitations, or diagnosis listed in the current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders™;

(d) Specify each staff member assigned to work with the recipient;

(e) Identify methods of involving the recipient's family or significant others if indicated;

(f) Specify criteria to be met for termination of treatment;

(g) Include any referrals necessary for services not provided directly by the **community**

mental health center[behavioral health services organization]; and

(h) The date scheduled for review of the plan.

(i) The recipient shall participate to the maximum extent feasible in the development of his or her plan of care and the participation shall be documented in the recipient's record.

(j)1. The **initial** plan of care shall be **developed [reviewed and updated]** through multidisciplinary team conferences as clinically indicated and at least thirty (30) days following the first ten (10) days of treatment.

2. The plan of care **for an individual receiving residential services for a substance use disorder or intensive outpatient program services** shall be reviewed every thirty (30) days thereafter and updated every sixty (60) days or earlier if clinically indicated.

3. The plan of care **for an individual receiving a service other than residential services for a substance use disorder or intensive outpatient program services** shall be reviewed and updated every six (6) months thereafter or earlier if clinically indicated.

4. A plan of care and each review and update shall be signed by the participants in the multidisciplinary team conference that developed it.

5. A plan of care **review[reviews]** shall be documented in the recipient's health record. [The Treatment Plan shall be reviewed at least every six (6) months and the record shall document the review.]”

(3) Subject: Staff Notes

(a) Comment: Dr. Lisa Willner, Executive Director of the Kentucky Psychological Association, and Dr. Sheila A. Schuster, Legislative Liaison of the Kentucky Psychological Association, stated the following:

“Page 3.15 5. Staff Notes. While the immediate reference is to Therapeutic rehabilitation services, there is reference here to ‘the staff note by any practitioner working under supervision shall be co-signed by the supervising professional within thirty (30) days’ which appears to apply generally to all staff for all services. Which ‘supervisor’ is required to sign the staff note? The ‘billing’ or ‘administrative’ supervisor or the clinical supervisor required by the licensure board? How will it be physically possible for any of these supervisors to be aware of every single contact with a recipient made by every staff member under their supervision? What is the rationale for requiring a signature on every staff note? This requirement will have a chilling effect on clinicians who are sought as “supervisors” – either clinical or ‘billing’ and may well result in the CMHCs having difficulty obtaining appropriate supervisors for their staff, particularly in rural areas. **We recommend that this requirement be significantly modified to be included in the monthly supervisory summary provided in 907 KAR 1:440 – page**

**10, lines 1-12.”**

(b) Response: DMS is clarifying the requirements in the manual by revising the language as follows:

**“5.[(5)] STAFF NOTES**

All staff notes shall be in chronological order, dated, entitled as to service rendered, have a starting and ending time for the services, and be recorded and signed by the staff person rendering the service with title (i.e., MSW, Psych., Prof. Eq., etc.). Family collateral, telephone and other significant contacts shall also be recorded in the staff notes.

All staff notes shall be recorded and signed by the staff person rendering the service. Initials, typed or stamped signatures are not acceptable.

**The staff note by any practitioner working under billing supervision shall be co-signed by the billing supervisor within thirty (30) days.**

**There shall be a monthly supervisory note recorded by the billing supervisor reflecting consultation concerning the case and the evaluation of services being provided to the recipient.**

For therapeutic rehabilitation services, the staff notes of the person delivering the service may be recorded daily, or if the CMHC prefers, as a weekly summary as long as the attendance worksheets are maintained. The weekly summary staff notes shall include a description of the clients’ symptoms or behavior, reaction to treatment, demeanor, changes in [treatment] plan of care, and need for continued treatment. Also a description of activities and how the activities were used to facilitate psychiatric therapy shall also be included in the staff note. ~~[The staff note by any practitioner working under supervision]~~~~[a paraprofessional]~~ **[shall be co-signed by the supervising professional within thirty (30) days]**~~[providing the service].~~

~~[Staff notes documenting outpatient services provided by a mental health associate shall be co-signed by the supervising professional.]~~ **[There shall be a monthly supervisory note by the professional reflecting consultation concerning the case and the professional’s evaluation of services being provided to the client.]”**

DMS believes the signature requirement is necessary to ensure quality of care and to document the supervisor’s involvement in treatment delivered by practitioners under supervision.

(c) Comment: Steve Shannon, Executive Director of the Kentucky Association of Regional Programs stated the following:

“It is recommended that the following language from Page 4.2 be amended:

Current Language – Ongoing consultation shall also be maintained with the supervisory staff throughout the duration of the recipient's treatment. Staff notes shall clearly reflect the input of the recipient. If a supervision professional was involved, the staff notes shall contain the supervising professional's signature.

Proposed amended language - Ongoing consultation shall also be maintained with the supervisory staff throughout the duration of the recipient's treatment. Staff notes shall clearly reflect the input of the recipient. ~~If a supervision professional was involved, the staff notes shall contain the supervising professional's signature.~~

Rationale for proposed amendment – It is recommended that the last sentence of the above language be deleted. This language is not required since the standard of good supervisory practice dictates that involvement in a recipient's service shall require documentation of that involvement. It is not necessary to include this requirement in the CMHC service manual.”

(d) Response: DMS prefers to keep the safeguard in the manual to ensure quality of care and to document the supervisor's involvement in treatment delivered by practitioners under supervision.

(4) Subject: Service Providers

(a) Comment: Dr. Lisa Willner, Executive Director of the Kentucky Psychological Association, and Dr. Sheila A. Schuster, Legislative Liaison of the Kentucky Psychological Association, stated the following:

“**Page 4.23** 3. Same comment and rationale as provided on Page 3.3 (6) for Program Director: We request that the following practitioners be added to the list of those authorized to provide psychiatric services to persons with an intellectual disability: **'licensed psychological practitioner, certified psychologist with autonomous functioning, licensed psychological associate, certified psychologist'.**”

(b) Response: As all practitioners are authorized to provide services to an individual with an intellectual disability DMS is removing the language altogether from the manual as follows:

“3. Limits Regarding Behavioral Health Services to Persons with an Intellectual Disability

When the client's diagnosis is intellectual disability, the client shall have an additional psychiatric diagnosis substantiating the need for psychiatric treatment. Diagnoses of developmental disorders (i.e., learning disabilities) shall not be acceptable. Services rendered to persons with intellectual disabilities in need of psychiatric services ~~[by a psychiatrist, psychologist, psychiatric nurse, licensed clinical social worker, licensed professional clinical counselor, licensed professional counselor associate, licensed marriage and family therapist or professional equivalent]~~

shall be covered by Medicaid when rendered in accordance with the psychiatrist's plan of care[treatment]."

(c) Comment: Dr. Lisa Willner, Executive Director of the Kentucky Psychological Association, and Dr. Sheila A. Schuster, Legislative Liaison of the Kentucky Psychological Association, stated the following:

"The last 12 pages of the Manual is an Appendix of Authorized Practitioners by Service. The titles 'Certified Psychologist with Autonomous Functioning' and 'Certified Psychologist' are missing from **EVERY** list. There are multiple listings per various pages. Especially glaring are these omissions in the section for Psychologist Testing on page 5 of the Appendix! **We request that these legal titles for Medicaid providers – 'Certified Psychologist with Autonomous Functioning' and 'Certified Psychologist' – be added to the list of authorized practitioners for each service, A through V, with the exception of S, Peer Support Services.**"

(d) Response: DMS is revising the manual by adding "certified psychologist with autonomous functioning" as an authorized practitioner for every service which may be provided by a "licensed psychological practitioner" and by adding "certified psychologist" as an authorized practitioner for every service which may be provided by a "licensed psychological associate."

(5) Subject: Services

(a) Comment: Dr. Lisa Willner, Executive Director of the Kentucky Psychological Association, and Dr. Sheila A. Schuster, Legislative Liaison of the Kentucky Psychological Association, stated the following:

**Page 4.5 9. Psychological Testing:** We request that the following statement be added to the description of psychological testing: "**Psychological testing is to be performed by persons who have met the requirements of KRS 319 related to the necessary credentials to perform such testing.**"

(b) Response: DMS is inserting the following statement into the manual:

**"Psychological testing shall be performed by an individual who has met the requirements of KRS Chapter 319 related to the necessary credentials to perform psychological testing."**

(c) Comment: Bart Baldwin, Director of Kentucky Health Resources Alliance, stated the following:

"Page 3.15 Regulation Language states Medication prescribing and monitoring shall be under the direction of a licensed psychiatrist, a licensed physician supervised by a psychiatrist, or an APRN certified in psychiatric-mental health nursing practice who meets the requirements established in 201 KAR 20:057, Section 2(1) and Section 6(1) -

(3). Prescriptions concerning medication shall not exceed an order for more than five refills.

Our comment is Physician Assistants (PA) have been removed from this section. As PAs work under the direct supervision of the psychiatrist, they should be allowed to provide medication, as this is within their licensure and scope of work.”

(d) Response: The manual did not previously list physician assistants. The provision in the manual does not list those who are authorized to prescribe medication but only states those under whose direction medication prescribing and monitoring may occur. As the respective professional licensure boards establish the parameters for medication prescribing and monitoring DMS is removing the language from the manual.

Related to this, though, DMS is inserting an option for CMHCs to utilize electronic prescribing. Following is the language related to this as well as a display of the aforementioned language that is being deleted from the manual:

**“6.[(B)] MEDICATION**

All medication prescribing and monitoring used in treatment shall be recorded in staff notes.

**“A CMHC with the capacity to use electronic prescribing may do so and shall be able to produce a hard copy of each prescription.**

**If a CMHC does not use electronic prescribing, the CMHC shall document each prescription [and] on a [special medication] form designated specifically for medications for easy reference and follow-up and keep[-] a copy of each[the] prescription issued [shall be filed] in the health record of each recipient for whom a prescription was issued.**

**[Medication prescribing and monitoring shall be under the direction of a licensed psychiatrist, a licensed physician supervised by a psychiatrist, or an APRN certified in psychiatric-mental health nursing practice who meets the requirements established in 201 KAR 20:057, Section 2(1) and Section 6(1) – (3).]**  
Prescriptions concerning medication shall not exceed an order for more than five **(5)** refills.”

(e) Comment: Bart Baldwin, Director of Kentucky Health Resources Alliance, stated the following:

“Page 4.5 Regulation language - This professional shall be present in the therapeutic rehabilitation program to provide direct, ongoing supervision and to serve as a source of guidance for other recipients of the therapeutic team.

Our comment is this wording prevents a Professional Equivalent or certified staff from covering the therapeutic rehabilitation program. The cost to operate the program will increase with having to have a licensed staff present in the program.

Some CMHCs have numerous staff who have received the Professional Equivalency from the Department for Medicaid Services for longer than 10 years, approaching 20 years. They are essential to the CMHC maintaining services needed in their communities. Due to educational and workforce opportunities, and limited rural resources as compared to urban areas, qualified people leave the rural areas in pursuit of economic personal advantages.

This requirement may reduce the size of the available behavioral health workforce in an unintended way.”

(f) Response: DMS is deleting the references to specific authorized practitioners of therapeutic rehabilitation services from that section of the manual as the list is incomplete and the manual elsewhere lists the authorized practitioners. Following is the list of practitioners authorized to provide therapeutic rehabilitation services:

“G. Therapeutic Rehabilitation Services

1. Psychiatrist
2. Physician
3. Psychiatric Resident
4. Resident Physician
5. APRN
6. Licensed Psychologist
7. Licensed Clinical Social Worker
8. Licensed Psychological Practitioner
9. Licensed Professional Clinical Counselor
10. Licensed Marriage and Family Therapist
11. Certified Social Worker
12. Licensed Psychological Associate
13. Licensed Professional Counselor Associate
14. Licensed Marriage and Family Therapist Associate
15. Physician Assistant
16. Psychiatric Nurse
17. Professional Equivalent
18. Mental Health Associate
19. Nurse
20. ~~[Certified Alcohol and Drug Counselor~~
- 24]. Licensed Professional Art Therapist
- 21.[22.] Licensed Professional Art Therapist Associate
- 22. Certified psychologist with Autonomous Functioning**
- 23. Certified psychologist.**”



(g) Comment: Bart Baldwin, Director of Kentucky Health Resources Alliance, stated the following:

**“Page 4.11** 16.a.1.c. ‘Be provided at least three (3) hours per day at least three (3) days per week; and’

908 KAR 1:310 and 908 KAR 1:370 describe Intensive Outpatient Program (IOP) as the following: Services are provided a minimum of six (6) hours over a period of two (2) or more days weekly. It will be difficult to meet requirements of both the above-referenced regulations and the manual.”

(h) Response: The requirements in the manual are those of DMS and are also in the corresponding state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS) which are the basis of federal funding for these services. DMS. For this reason DMS does not wish to change the requirement.

(i) Comment: Bart Baldwin, Director of Kentucky Health Resources Alliance, stated the following:

**“Page 4.18** 21.a.1.c. Meet the requirements for comprehensive community support services established in 908 KAR 2:250.

This regulation states the person is to have 1 year experience.

It is becoming extremely difficult to hire staff who have 1 year experience in the mental health field.

**SUGGESTION:**

As training is required **and** the community support services staff is to work under supervision of staff, training should suffice for providing this service.”

(j) Response: DMS and DBHDID staff believe that the requirement is appropriate as is.

(6) Subject: Language and Clarity

(a) Comment: Kathy Adams, Director of Public Policy for the Children’s Alliance stated the following:

“Page 1, Line 15-16 Recommend that language be added to the ‘Necessity, function and conformity’ section to clarify that this regulation applies to Medicaid recipients that are or are not enrolled with a managed care organization.”

(b) Response: DMS is revising the Necessity, Function, and Conformity paragraph as follows to clarify that the coverage provisions and requirements apply to the whole Medicaid Program. As “Medicaid recipients” include Medicaid recipients who are not enrolled with a managed care organization as well as those who are [defined as

“enrollees” in Section 1(3)] DMS believes that the revised language is adequate. Below is the revised language:

“This administrative regulation establishes the **Medicaid Program** coverage provisions and requirements regarding community mental health center (CMHC) **behavioral health services provided to Medicaid recipients.**”

(c) Comment: Kathy Adams, Director of Public Policy for the Children’s Alliance stated the following:

“Page 3, Line 16 Section 4(1)(a) through (u) includes a list of rehabilitative mental health and substance use disorder services covered under this regulation. The conjunction used in the list is ‘or’, which is interpreted that the CMHC could provide one or any of these services. What determines which services from this list a CMHC must provide? Is this prescribed in regulation?”

(d) Response: Services that a CMHC must provide is prescribed in a chapter of Kentucky Revised Statutes which establish the Regional Community Mental Health Program Board which is responsible for CMHCs in Kentucky. The related Kentucky Revised Statutes are KRS 210.370 – 485 and the specific KRS that establishes services that must be provided is KRS 210.410. The statute states:

**“210.410 State aid for regional mental health and intellectual disability programs.**

(1) The secretary of the Cabinet for Health and Family Services is hereby authorized to make state grants and other fund allocations from the Cabinet for Health and Family Services to assist any combination of cities and counties, or nonprofit corporations in the establishment and operation of regional community mental health and intellectual disability programs which may provide primary care services and shall provide at least the following services:

- (a) Inpatient services;
- (b) Outpatient services;
- (c) Partial hospitalization or psychosocial rehabilitation services;
- (d) Emergency services;
- (e) Consultation and education services; and
- (f) Services for individuals with an intellectual disability.

(2) The services required in subsection (1)(a), (b), (c), (d), and (e) of this section, in addition to primary care services, if provided, shall be available to the mentally ill, drug abusers and alcohol abusers, and all age groups including children and the elderly. The services required in subsection (1)(a), (b), (c), (d), (e), and (f), in addition to primary care services, if provided, shall be available to individuals with an intellectual disability. The services required in subsection (1)(b) of this section shall be available to any child age sixteen (16) or older upon request of such child without the consent of a parent or legal guardian, if the matter for which the services are sought involves alleged physical or sexual abuse by a parent or guardian whose consent would otherwise be required.”

Below is the Web site address of KRS 210.410:  
<http://www.lrc.ky.gov/Statutes/statute.aspx?id=43455>

(e) Comment: Kathy Adams, Director of Public Policy for the Children's Alliance stated the following:

"Page 7, line 17-20 Section 7(2)(a)2.a.-c. Indicates that recipient's health record will contain a screening, assessment and disposition. It seems unlikely that 'all' recipients' health record would include an assessment as some recipient's may not remain a client long enough for an assessment to be completed. Recommend provisions be added to provide flexibility in regards to this requirement when a recipient does not remain a client long enough for an assessment to be completed."

(f) Response: DMS and DBHDID staff believe that an assessment is an appropriate requirement for all recipients who present at a CMHC.

(g) Comment: Kathy Adams, Director of Public Policy for the Children's Alliance stated the following:

"Page 8, line 6 2. requires a recipient's health record to be 'furnished to the Cabinet upon request;' This provision seems overly board as the Cabinet includes many different Departments, Offices and Divisions (i.e. Department for Community Based Services) that should not automatically be privy to a recipient's health record unless authorized by the client. Request that this provision be amended to more specifically state which Cabinet entities are authorized to have automatic access to a recipient's health record. Additionally, should this requirement apply to a Managed Care Organization for enrollees' health records? If so, recommend that appropriate language be added."

(h) Response: Only Cabinet for Health and Family Services agencies which have legal access to such records would attempt to obtain the record. The cabinet has undergone reorganizations almost regularly and DMS would prefer to keep the language as is in the event that a given agency is renamed in the future.

Regarding managed care organization access, DMS is revising the language as follows via an "amended after comments" administrative regulation:

"(b) Be:

1. Maintained in an organized central file;
2. Furnished to the:

**a.** Cabinet for Health and Family Services upon request; **or**

**b. Managed care organization in which the recipient is enrolled if the recipient is enrolled with a managed care organization;.**"

(i) Comment: Kathy Adams, Director of Public Policy for the Children's Alliance stated the following:

"Page 8, Line 14-15 Recommend that the individual that provided the service be allowed 48 hours to sign the health record, which is consistent with other DMS regulation provisions, including (7)(a)1. of this Section."

(j) Response: DMS is adopting the recommendation via an "amended after comments" administrative regulation.

(k) Comment: Kathy Adams, Director of Public Policy for the Children's Alliance stated the following:

"Page 8, line 21 Recommend adding the word 'health' before the word 'record' for clarity so that line 21 reads, '...recipient's health record for the longest of.'"

(l) Response: DMS is revising the term as recommended via an "amended after comments" administrative regulation.

(m) Comment: Kathy Adams, Director of Public Policy for the Children's Alliance stated the following:

Page 12, line 5 Recommend adding the word 'health' before the word 'record' for clarity so that line 5 reads, '..... transfer the recipient's health records in a manner that.....'"

(n) Response: DMS is revising the term as recommended via an "amended after comments" administrative regulation.

(o) Comment: Kathy Adams, Director of Public Policy for the Children's Alliance stated the following:

Page 12, line 16 Recommend adding a comma after the word 'referral' and before the word 'transfer' for clarity so that line 16 reads, '....hours of the transfer or referral, transfer the recipient's.....'"

(p) Response: With DMS's permission, Legislative Research Commission (LRC) staff inserted the comma via a technical amendment subsequent to DMS filing the administrative regulation with LRC.

(q) Comment: Kathy Adams, Director of Public Policy for the Children's Alliance stated the following:

"Page 12, line 16 Recommend adding the word 'health' before the word 'record' for clarity so that line 16 reads, '..... transfer the recipient's health records in a manner that.....'"

(r) Response: DMS is revising the term as recommended via an “amended after comments” administrative regulation.

(s) Comment: Kathy Adams, Director of Public Policy for the Children’s Alliance stated the following:

“Page 13, line 14-17 Recommend that provisions be added to include duplicate payment or overpayment made by a managed care organization like (2)(a) and (b) currently prescribes for the department.”

(t) Response: DMS is incorporating the recommendation into an “amended after comments” administrative regulation.

(u) Comment: Kathy Adams, Director of Public Policy for the Children’s Alliance stated the following:

“Page 13, line 21 Recommend that provisions be added to Section 10 to provide a managed care organization the same authority to audit any claim, medical record or documentation associated with any claim or medical record for an enrollee, as provided to the department.”

(v) Response: DMS is incorporating the recommendation into an “amended after comments” administrative regulation.

(w) Comment: Kathy Adams, Director of Public Policy for the Children’s Alliance stated the following:

“Page 13, line 21-23 Recommend changing the word ‘medical’ to ‘health’ so that ‘health record’ is the consistent phrase used throughout this regulation and other related regulations, if ‘medical record’ and ‘health record’ refer to the same thing. . If the phrases have different meanings, then we recommend that these phrases be defined in Section 1 to clarify the difference.”

(x) Response: DMS is revising the term as recommended via an “amended after comments” administrative regulation.

(7) Subject: Licensed Clinical Alcohol and Drug Counselors/Licensed Clinical Alcohol and Drug Counselor Associates

(a) and (b) Comment and Response: In response to legislation (HB 92 of the 2015 Regular Session of the General Assembly) DMS is adding “licensed clinical alcohol and drug counselors (LCADCs) and licensed clinical alcohol and drug counselor associates (LCADCAs) to the list of authorized practitioners for services for which certified alcohol and drug counselors are already authorized to provide. DMS is inserting a caveat that this change will be contingent and effective upon approval by the Centers for Medicare and Medicaid Services as DMS must procure federal approval and federal funding for the change.

SUMMARY OF STATEMENT OF CONSIDERATION  
AND  
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 1:044 and is amending the administrative regulation as follows:

**Page 1**

**Necessity, Function, and Conformity**

**Line 15**

After “establishes the”, insert “Medicaid Program”.

**Line**

After “health services”, insert “provided to Medicaid recipients”.

**Page 7**

**Section 7(2)(a)2.**

**Line 18**

After “Screening”, insert the following:

if the community mental health center performed the screening

**Page 8**

**Section 7(2)(b)2.**

**Line 6**

After “the”, insert a colon, a return, and “a.”.

After “request;”, insert the following:

or

b. Managed care organization in which the recipient is enrolled if the recipient is enrolled with a managed care organization;

**Page 8**

**Section 7(3)**

**Line 14**

Before “on the”, insert the following:

within forty-eight (48) hours of

Delete “on”.

**Page 8**

**Section 7(4)(b)**

**Line 21**

After “recipient’s”, insert “health”.

**Page 12**

**Section 7(13)(a)**

**Line 5**

After “recipient’s”, insert “health”.

**Line 6**

After “with the”, insert “health”.

**Page 12**

**Section 7(13)(b)**

**Line 16**

After “recipient’s”, insert “health”.

**Line 17**

After “with the”, insert “health”.

**Page 13**

**Section 8(2)(a)**

**Lines 14 and 15**

After “from the department”, insert “or managed care organization”.

**Line 15**

After “to the department”, insert the following:  
or managed care organization that issued the duplicate payment or overpayment

**Page 13**

**Section 10**

**Line 21**

After “department”, insert the following:  
or the managed care organization in which an enrollee is enrolled

After “any”, insert a colon, a return, and “(1)”.

**Line 22**

After “claim”, insert a semi-colon, a return, and “(2) Health”.  
Delete “, Medical”.

After “record”, insert a semi-colon and delete the comma.

**Line 22**

After “or”, insert a return and “(3)”.

**Line 23**

After “claim or”, insert “health”.  
Delete “medical”.